

Project Narrative

Section 1: Accomplishments and Barriers

The Illinois Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) led by the Illinois Governor's Office of Early Childhood Development and the Illinois Department of Human Services had significant accomplishments in 2012. From the development and implementation of Coordinated Intake in the six MIECHV targeted communities to the support of an infrastructure linking a system of almost 300 home visiting programs, Illinois has leveraged the MIECHV grant to improve the quality of life for high risk children and families.

- Accomplishments in 2012:
 - Development of the Coordinated Intake Assessment Tool (CIAT) used in communities to match participant needs to home visiting model.
 - Implementation of the 4 P's Plus screening tool for maternal depression, tobacco use, substance abuse, and domestic violence. A coordinating Brief Intervention Tool was used if the woman screened positive. Illinois has 2 quarters of data analysis regarding the use of this tool.
 - All MIECHV home visitors have received home visiting model core training, 40 hour domestic violence certification, and receive reflective supervision on a regular basis consistent with model requirement.
 - All MIECHV home visitors and supervisors have received training on domestic violence, substance abuse, mental illness, and parents with special needs. Advanced training on these topics will begin in 2013.
 - Illinois procured a data system that was requested by the majority of the MIECHV home visitors. DataKeeper is being augmented for use in Illinois within all six MIECHV communities with anticipated statewide use. A data element crosswalk has been developed across all major home visiting funders within Illinois to support a common data system.
 - Along with the six targeted communities, five counties have voluntarily become part of the MIECHV system and are implementing Coordinated Intake and Community System Development. They are eligible for support from the MIECHV Project Director, all MIECHV trainings and the data system.
 - Infant Mental Health Consultation (IMHC) has been implemented in all six targeted communities.
 - Futures Without Violence Healthy Moms, Healthy Babies has been introduced in the six communities. The training is slated to be developed and offered throughout the state in 2013
 - Mother's and Babies curriculum for maternal depression will be implemented in the six communities and throughout the state. IMHC will provide clinical support for the program.
 - The Illinois Chapter of the American Academy of Pediatrics developed a tool and training for primary care providers (PCP) in the six communities. This tool and associated trainings have improved coordination and communication between the PCP, home visitors, and participant. This will be taken statewide in 2013.
 - The Illinois Birth to Three Training Institute of the Ounce of Prevention Fund

- developed core competencies and training curriculum for Coordinated Intake (CI) workers and supervisors and is working on the same for Community Systems Development workers around the Collective Impact model.
- The *Mobile* video, the third video in the series *Stories for Children That Grownups can Watch*, will be released in September 2013 with commentary from Dr. Bruce Perry. This video series addresses the needs of children who are exposed to trauma. The *Mobile* video specifically addresses this issue from an infant's perspective.
- Data collection and analysis on all benchmarks has begun in MIECHV communities
- The Illinois Continuous Quality Improvement (CQI) Plan for improvement in Home Visiting was developed and approved by HRSA and the Illinois Home Visiting Task Force for use in Illinois. CQI meetings have begun. The "Quality Koala" is the icon used to represent this process in Illinois.
- The major funders of home visiting in Illinois met for the first time to look at common goals and outcomes across funding streams.
- Illinois produces a quarterly MIECHV newsletter. This newsletter provides important information, updates, due dates, contacts, and trainings to all involved in Illinois MIECHV.
- Illinois is investing in an "iGrow" public awareness campaign. This campaign will focus on normalizing home visiting, the importance of good prenatal care and child development.
- Barriers and Challenges in 2012:
 - Illinois invested a year in development of a data system that did not return the results desired. In May 2013, a new data system was implemented, but this slowed Illinois' ability to analyze some of the data collected. Illinois is now working to rectify this issue.
 - Illinois has implemented coordinated intake in the six targeted communities, but not all agencies/programs in the communities have agreed to fully participate. There remain trust issues in filling caseloads. This is in part due to the financial requirement of some funders that programs maintain a certain caseload.
 - MIHOPE randomized controlled trial has come into four of the six MIECHV communities in Illinois. This has placed an incredible burden on these communities to maintain full caseloads.
 - Some communities did not adhere to the Illinois recommended qualifications for the Community Systems Development worker. Consequently, the communities had poor outcomes resulting in staff replacement. The state now requires state-level review of resumes of the final three applicants for these positions.
 - There is a need for additional support for CI and CI Supervisors in some sites where there were some transparency issues about how referrals were being made.

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 Maternal, Infant, and Early Childhood Home Visiting Formula Grant
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Name of Community	Name of Agency	Model	Current Capacity	Number of clients served to date	Cost Per Family
Cicero	Childrens Center of Cicero-Berwyn	PAT	60	73	\$1,731.00
	Family Focus Inc (Nuestra Familia)	PAT	77	95	\$2,922.08
	Family Services & Mental Health	CI ¹ & CSD ²	N/A	N/A	N/A
Elgin	Family Focus DuPage Inc	HFI	23	25	\$4,822.00
	Kane County/Health Department	NFP CI & CSD	18	12	\$2,777.00
	School District U-46	PAT	33	48	\$2,832.78
	VNA Fox Valley	HFI	25	23	\$3,071.00
Macon County	Decatur Public School	PAT	30	36	\$2,870.42
	Macon County Health Department	HFI CI & CSD	18	22	\$8,957.45
	Macon Resources	PAT	28	31	\$2,903.23
Rockford	Easter Seals Metropolitan	HFI	28	43	\$2,457.00
	La Voz Latina	HFI	18	13	\$5,162.00
	Rockford City of / Human Services	EHS	23	28	\$7,881.00
	Rockford Public Schools Dist 205	PAT	30	43	\$2,457.00
	Winnebago County Health Department	CI & CSD	N/A	N/A	N/A
SELN (Englewood, W. Englewood, Greater Grand Crossing)	Children's Home + Aid	CI & CSD	N/A	N/A	N/A
	ChildServ	PAT	38	53	\$3,150.00
	Comm Organizing & Family Issues (COFI)	CSD	N/A	N/A	N/A
	Family Focus Inc	HFI	15	30	\$3,124.99
	Henry Booth House	HFI	40	40	\$3,125.00
	The Women's Treatment Center	PAT	20	68	\$1,765.00
Vermilion County	Project Success	CSD	N/A	N/A	N/A
	Aunt Martha's	PAT & CI	60	86	\$5,450.00
	Danville Community Consolidated	PAT	12	23	\$3,043.47
	East Central Community Action	EHS	20	27	\$10,932.00

Cost per family is calculated as follows: amount of MIECHV funding (by agency) divided by

¹ Coordinated Intake

² Community Systems Development

Section 2: Home Visiting Goals and Objectives:

- Progress made under each goal and objective:

The goals and objectives for Illinois' Strong Foundations Partnership reflect four essential elements of our strategy: 1) operating home visiting programs with fidelity to their models; 2) developing strong referral networks for home visiting program participants in order to achieve the national benchmarks; 3) testing a universal screening and coordinated intake system; and 4) strengthening the early childhood service delivery system.

The goals and objectives are as follows:

1. The statewide system of evidence-based and innovative approaches to home visiting and the state and local infrastructure necessary to support effective service delivery will be enhanced.

1.1 Implement or expand evidence-based and innovative home visiting models and test service delivery enhancements in selected target communities. *Implemented and ongoing*

1.2 A system to screen all pregnant women and families with newborns and link them to a full array of perinatal and early childhood services will be developed and tested in at least one target area. *Not yet implemented. The Illinois Home Visiting Task Force, under the Illinois Early Learning Council, has established a Universal Screen Workgroup led by researcher, Deb Daro. The aim of this workgroup is to develop a statewide definition of universal screening and methods to implement. Illinois, however, did not have a coordinated intake process until the MIECHV grant, and it was decided that the coordinated intake process needed to precede the universal screening. Coordinated intake is now implemented in the six MIECHV targeted communities, and the Universal Screen Workgroup concurrently meets to discuss the necessary components of the universal screen. Barrier #1: Accessing real time birth information has proven challenging in Illinois as this information is held outside of the Illinois Department of Human Services (IDHS) (which administers the MIECHV grant). There have been ongoing discussions between the Governor's Office, the Illinois Department of Healthcare and Family Services (IHFS), and the Illinois Department of Public Health (IDPH) regarding how to access this information and data exchange agreements. Barrier #2: Accessing hospital maternity wards has proven difficult due to the hospitals' misunderstanding of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Governor's Office is developing a document that will be reviewed by hospital attorneys to explain that home visiting screening on maternity floors is not a violation of HIPAA. Due to bureaucracy within hospitals, this process has been slow.*

1.3 The agencies and individuals in the target areas that serve families with young children are organized into an effective and efficient service delivery system. *In the two and a half years that MIECHV has been implemented in the six targeted communities, these communities have continued to develop their collaborative to support a quality service delivery system. Based on Collective Impact model, the Community Systems Development and Capacity Building Manager has worked within each of the communities to strengthen their service delivery system. This process is ongoing.*

1.4 The state agencies that belong to the Strong Foundations Partnership will develop and maintain the staff capacity, information technology and partnerships required to support the operation of high-quality, effective home visiting programs. *Implemented and ongoing.*

2. Home visiting programs operate with fidelity to national models

2.1 Program staff meets the national model's education, experience and professional licensure requirements, reflects the cultural and linguistic diversity of the community they serve and demonstrates cultural competence. *Implemented and ongoing.*

2.2 Program staff completes the training required for their role in the project. *Implemented and ongoing.*

2.3 Program staff regularly receives reflective supervision. *Implemented and ongoing.*

2.4 The home visiting program's caseload remains at or above 75% of capacity. *Implemented and ongoing, however, home visiting programs' caseloads often fluctuate due to staff and participant attrition. The programs are working diligently to maintain capacity at a minimum of 75%.*

2.5 The home visiting program provides at least 75% of the expected number of complete visits for 75% of participating families. *Implemented and ongoing. Quarterly reports by the agencies allow IDHS and the Governor's Office to monitor this expectation. The most difficult level to maintain is the level with the highest dosage, and this sometimes fluctuates due to multiple issues. Illinois changed information systems from ETO to DataKeeper in May 2013. Programs are entering back data so that the state will be able to monitor this objective through its data system.*

2.6 The home visiting program collects information about its operation and uses that information to improve performance. *Implemented and ongoing. The Center for Prevention and Research Development (CPRD) at the University of Illinois at Urbana-Champaign has developed a state continuous Quality Improvement Plan for home visiting. The Illinois Home Visiting Taskforce ratified this plan as the state home visiting Continuous Quality Improvement (CQI) plan. Health Resources and Services Administration (HRSA) approved the Illinois CQI plan.*

3. Home visiting programs are embedded in the overall system of services for families with young children.

3.1a Local home visiting programs will execute Memoranda of Understanding (MOU) or other formal agreements with preventive and primary health care, mental health, substance abuse, domestic violence, developmental disability, homeless, early learning providers, and Limited English Proficiency service providers in the community, regional perinatal care services and Early Intervention access points. *Implemented and ongoing. The Governor's Office and IDHS monitor each agency's work and MOUs with the service providers within this objective. It is stressed (with constant reminders) the inclusion of these service providers within the*

collaborative is paramount to MIECHV and the success of home visiting. Furthermore, the Illinois MIECHV grant supported the Illinois Chapter of the American Academy of Pediatrics' (ICAAP) work with primary medical care providers and home visiting programs. This work supports the six targeted communities to improve their coordination and information exchange on behalf of the participants. Due to the pilot program's success, it is being implemented throughout the state.

3.1b Local home visiting programs will execute Memoranda of Understanding or other formal agreements with other social service providers in the community. *Implemented and ongoing. The governor's office and IDHS continually monitor that programs are increasing their MOUs with community service providers to improve services to participants and increase referrals to the home visiting program.*

4. Home visiting programs improve the lives of participating families in the areas described by the national benchmarks

Implemented and ongoing. The objectives listed below are being implemented by agencies within the six targeted communities. The impact of their services is being monitored by CPRD, which is using field data collectors with specific data collection tools that monitor the progress of objectives 4.1a through 4.6b. Additionally, researchers are pulling data from the MIECHV program data system to further assess the progress of the objectives. Each of these objectives relates to a part of the Illinois Benchmark Plan, and the plan states the specific metrics. Barrier: Illinois MIECHV's initial data collection system was Social Solutions, Efforts to Outcomes. After a period of 12 months of working with Social Solutions, Illinois recognized this data system would be unable to collect, aggregate, and analyze data needed for 4.1a through 4.6b. This is due, in part, to this specific system's hard coding versus soft coding and relational issues. In January 2013, an RFP was released for a new data system. In May 2013, DataKeeper Visit Tracker was awarded the Illinois MIECHV data system contract. Illinois has been diligently working with the programs to enter back data and with the data system to develop the analysis required.

4.1a. Home visiting programs improve the health of women by helping them gain health insurance coverage, by linking them to preconceptional, prenatal and primary care services, through screening for perinatal mood disorders, substance abuse, developmental delay and other conditions, and by linking women to community services to address these conditions. (This is the portion of Benchmark 1 that applies to women of child-bearing age.)

4.1b. Home visiting programs improve the health of children through the promotion of breastfeeding, by helping them gain health insurance coverage and by linking them to preventive and primary care services. (This is the portion of Benchmark 1 that applies to children.)

4.2 The rate of childhood injury, abuse and neglect among participating families and reduction of emergency department visits will decrease over time. (This is part of Benchmark 2.)

4.3a Parents in participating families will improve their knowledge of child development,

improve their parenting skills and avoid the use of harsh discipline in order to promote their children's cognitive, emotional and social development. (This is part of Benchmark 2.)

4.3b. Children in participating families will meet developmental milestones for cognitive, language, motor, social and emotional development; children who exhibit developmental delays will be linked to Early Intervention services. (This is part of Benchmark 3.)

4.4 Participating families will be screened for the presence of intimate partner violence; affected partners are referred for services and develop a safety plan. (This is Benchmark 4.)

4.5 Participating families will increase their educational attainment, employment and household income and obtain health insurance coverage. (This is Benchmark 5.)

4.6a Participating families affected by any of Illinois' six high risk conditions³ are identified and linked to additional assessment and treatment services. (This is part of Benchmark 6.)

4.6b Participating families are screened or assessed for their need of additional health or social services and are linked to available service providers. (This is part of Benchmark 6.)

- Updates or revisions to program goals and objectives not previously reported to HRSA: None

- Home Visiting is Part of a Comprehensive System:

Home visiting programs play a critical role in the development of a comprehensive, high-quality early childhood system. Federal funding for Evidence-Based Home Visiting, MIECHV FY10, FY11, and FY12 Formula Grant, Early Childhood State Advisory Council (SAC) Grants, and Title V provide the opportunity for multiple, integrated early childhood programs to work in collaboration to build a stronger, integrated, early childhood system.

Home visitors provide support and bring knowledge of child development and community services to families who may be isolated by service barriers (e.g., transportation or language) or who may be affected by circumstances that interfere with the development of a healthy bond with their young children (e.g., a perinatal mood disorder). Providing services in the home setting allows a more complete understanding of the family's needs and circumstances. Home is the child's natural and most comfortable environment.

Illinois' goals and objectives were developed to incorporate the role of home visiting programs in a comprehensive system. For this system to be effective we have been creating a structure to connect home visiting professionals and medical homes for the purpose of enhanced care coordination.

The American Academy of Pediatrics (AAP), in its policy statement "The Role of Preschool Home Visiting Programs in Improving Health and Developmental Outcomes" (February 2009), recommends that pediatricians should become aware of and participate in development of home-visiting programs in their communities. It also states that there is ample reason to believe that the synergy of home visitors working with pediatric clinicians could have

³ Maternal perinatal mood disorders, substance abuse, intimate partner violence, parental developmental delay, homelessness and limited English proficiency.

positive effects on child health and development, and calls for free-flowing communication between home visitors and pediatricians. Goal 1 and objectives 1.2 and 1.3 have been developed for this aspect of the project.

Other AAP clinical policy further strengthens the need for medical homes to link with home visiting and related community services, citing the relationship to developmental screening and referral (now recommended) and their benefit in terms of school readiness (benchmark 3). Connection with a home visitor gives the physician a view into the family's home life and can be critical to his or her ability to provide care. The home visitor can share information to both reinforce anticipatory guidance and help shape care plans and recommendations; such information might cover environmental and safety risks in the home availability of positive supports (books, safe play spaces), and potential domestic violence (benchmark 4), abuse, or substance use. Objective 4.1a and 4.4 have been developed for this aspect of the project.

Tying a medical home with home visiting services is consistent with Illinois' Title V program priorities. Specifically, this inclusion directly address the Illinois priority to "integrate medical and community-based services for MCH populations and improve linkage of clients to these services, particularly CSHCN" by linking medical homes with home visiting. Furthermore, it directly addresses the priority to "expand availability, access to quality, and utilization of medical homes for all children and adolescents, including CSHCN" by providing medical homes with links to additional services and thereby improving the medical home's ability to provide comprehensive, needed services. Working on this issue with medical homes, their professional organizations, and health professional training programs has further strengthened Illinois Title V through partnerships and access to expertise.

To improve coordination of services, primary care physicians (PCP) and medical homes directly address improved coordination for at risk communities. One requirement of a medical home is to coordinate care with community services such as home visiting. Through work with ICAAP, this referral and coordinating process has been defined. These activities support identification of barriers and strategies to improve coordination between medical homes and home visiting. The work in ICAAP has encouraged practices to overcome the barriers and implement effective strategies for improved coordination. Objective 4.1a has been developed for this aspect of the project. Families are benefiting from home visitors' enhanced abilities to identify the more difficult to access resources (for substance abuse, mental health) by coordinating care with PCPs, who may have related professionals in their routine referral network, or who may have those services on site (for instance, at community clinics that often have co-located services, or hospital-based practices that have access to a wide variety of specialists), or who can consult with Illinois Health Connect for referral assistance.

In addition to strengthening the link between medical homes and home visiting as part of the implementation of home visiting programs at the community level, the Strong Foundations Partnership will continue its efforts to develop the state and local infrastructure required to support the effective operation of home visiting programs. One of the system enhancements being planned will be the development and testing of a universal screening. Coordinated intake in the MIECHV communities has been implemented.

The Partnership draws on the state's experience with development and implementation of the All Our Kids (AOK) Early Childhood Networks and other collaborative initiatives to strengthen the early childhood service delivery system in the MIECHV target areas. The community systems workgroup of the state's Early Learning Council developed technical assistance tools that also aid in this effort. As part of an integrated approach supporting home

visiting, the state provides training of home visitors, monitoring local program operations and continuously improving their quality through the analysis of program data and the provision of additional technical assistance and training. This integrated approach is intended to support home visiting programs of all types, whether they are established, evidence-based models or innovative, promising approaches. In support of this effort, the Executive Committee planned for the EBHV grant (now complete) and MIECHV grant synergistically. Goal 1 and objectives 1.1 through 1.4 have been developed for this aspect of the project.

To be effective, each home visiting program has been required to operate with fidelity to the guidelines established by its model developer and use management information to continuously improve the quality of service delivery. Goal 2 and objectives 2.1 through 2.6 are proposed to address this aspect of the initiative.

Home visitors bring information and help new parents promote their children's development and reduce their risk of injury or maltreatment. They also link families to other community services, such as preventive and primary health care, mental health and substance abuse treatment services, domestic violence shelters and services, child care, transportation, education, employment, food, shelter, income assistance, and many others. The acquired access to the Illinois Department of Children and Family Services (DCFS) Service Provider Database (SPD) helps facilitate appropriate and timely referrals. The connection of ancillary services through this database builds a stronger, more integrated service community. Goal 3 and objectives 3.1a and 3.1b and Goal 4 and objectives 4.1 through 4.6 are proposed to address the improvement of parents' knowledge of child development and to address the importance of linkages to community services in order to improve the health of participating families and achieve the national benchmarks for the MIECHV.

The logic model developed for Illinois' Maternal, Infant and Early Childhood Home Visiting Program summarizes the four basic components of Illinois' strategy: universal screening and coordinated intake; operating home visiting programs with fidelity to national models; connecting home visiting programs to the providers of services required by Illinois' high-risk target populations, including medical homes; and developing an effective and coherent early childhood service delivery system. There have been no updates or changes to the logic model. An updated timeline of activities is presented in attachment 1.

Section 3: Update of the State Home Visiting Promising Approach

Illinois is not funding a promising approach in its MIECHV formula grant.

Section 4: Implementation of State Home Visiting Program in Targeted At-Risk Communities

Illinois MIECHV continues to be provided in the six-targeted communities of Chicago's Southside Cluster (Englewood, West Englewood, and Greater Grand Crossing), Cicero, Elgin, Rockford, Macon County, and Vermilion County. Additionally, five Illinois counties have voluntarily agreed to implement the MIECHV coordinated intake system within their home visiting programs. These counties are Stephenson, Peoria, McLean, Piatt, and Dewitt. Although not specifically funded by MIECHV, these counties have been given small stipends (\$15,000 to \$25,000) to support the building of the coordinated intake infrastructure. They are also provided support from the Illinois Governor's Office of Early Childhood Development (GOECD) and IDHS for both coordinated intake and community systems development. Two primary challenges face the MIECHV communities. One is the need for a supportive and interrelated

data system, and the second is increasing the level of trust among home visiting providers to ensure a true coordinated intake system. To counter these challenges, the GOECD and IDHS listened to the complaints, desires, and needs of the agencies for a different and improved data collection system. In May 2013, the data collection system was changed to the system preferred by the majority of providers. The Community Systems Development and Capacity Building Manager, along with a contracted Community Impact Officer, provide technical support to each community collaborative to improve and increase trust among partners. The Illinois Birth-to-Three Training Institute (IBTI) in the Ounce of Prevention Fund has been contracted to develop the core competencies of the community systems development worker, coordinated intake worker, and an associated training curriculums.

- Illinois is fortunate to maintain several connections with national model developers to ensure that home visiting programs in the state receive up-to-date and timely support regarding model fidelity and adherence. Staff members from lead agencies hold positions on the Healthy Families America (HFA) Credentialing Panel and the HFA Training Advisory Council, as well as the Parents as Teachers State Leaders work group. The Ounce of Prevention Fund (the Ounce) serves as the Parents as Teachers State Office in Illinois and as such provides direct assistance and guidance to all Parents as Teachers (PAT) programs in Illinois. In FY12, this support included individualized technical assistance to 153 programs throughout the state. State agencies worked collaboratively to conduct capstone activities related to a State Advisory Council (SAC) Grant. This work included focused attention on a quality assurance project for PAT and HFA programs throughout the state, as well as the convening of a statewide, model inclusive home visiting summit. Out of this summit Illinois will produce a white paper with findings and suggestions for enhancing the quality of home visiting in the state.

- Curricula and all other needed materials have been acquired by all programs within the targeted communities. Additionally, for those programs across the state that do not have the current edition of an evidence-based curriculum or no curriculum, support has been provided for those programs to acquire such.

- Illinois provides home visiting programs with a comprehensive competency-based professional development system to support home visiting staff with skill building and increased proficiency in their work with families. The Ounce of Prevention Fund serves as the state training entity for programs utilizing an evidence-based home visiting model. Ounce staff includes trainers certified by the national models to train HFA and PAT core training. The Ounce provided core training to approximately 130 new HFA and 180 new PAT staff in FY12. PAT recertification training for PAT staff also ensured that all existing PAT staff became trained in the most recent release of the PAT Foundational and Model Implementation training. Prevent Child Abuse America is preparing to release their latest version of the HFA core training curriculum. Once this process begins, Illinois will host a regional HFA train-the-trainer recertification training for currently certified HFA trainers. This recertification process will ensure that HFA program staff in Illinois receives the most current model information.

- All communities have completed staff recruitment and hiring; however, retention of staff in some areas has been problematic. The Nurse Family Partnership (NFP) program in Elgin has had one staff position turnover twice. In some areas, staff retention has been impacted by the data collection requirements of MIECHV, particularly in areas where other home visiting funders have little to no data collected. This dichotomy is not so much an issue with MIECHV as it is an issue of lack of data collection by the other funder. This lack of data collection by the other funder is being addressed through CQI and the Illinois Home Visiting Taskforce.

Because home visiting is a relationship-based service, a stable work force is critical. Agencies recognize this important fact and “brainstorm” with GOECD and DHS on creative ways to retain home visitors. Increased salaries, flexible workweeks, laptops, cell phones, and sufficient supplies have been encouraged by the state, and if possible, adopted by the agencies. Furthermore, Illinois is working to professionalize the home visiting career path. While some home visiting models allow for paraprofessional staff, the majority of home visitors in Illinois have a Bachelor or Master’s level education.

Training and support offered by IBTI have helped with staff retention. IBTI is recognized on a national basis for providing high quality training using adult learning standards with multi-sensory application. IBTI believes in and practices the parallel process. Trainings are well developed and presented in a manner that supports respect, kindness, and understanding. DHS and GOECD worked in partnership with IBTI to provide additional core trainings for MIECHV home visiting staff. Additionally, the following ancillary trainings were offered for MIECHV home visiting staff to enrich practice and support the MIECHV plan in Illinois:

- 4 Ps Plus
- Impact of Prenatal Substance Abuse
- Futures Without Violence - Happy Moms, Healthy Babies
- Mental Health First Aid
- Learning Communities
- Quality Home Visiting Summits
- 40 Hour Domestic Violence Certification Training
- Continuous Quality Improvement
- Medical Home Coordination: Training by the IL Chapter of the American Academy of Pediatrics
- Infant Mental Health Consultation
- Abriendo Puertas (Open Doors) - Parent Involvement training targeted to Latinos

To be offered statewide in MIECHV and non-MIECHV home visiting communities in 2013:

- Mothers & Babies Maternal Depression curriculum
- Futures Without Violence - Happy Moms, Healthy Babies (in development)
- Intrapartum Spacing and Contraception
- Collective Impact training
- Coordinated Intake and Community Systems Development Learning Communities
- Supervisory Learning Communities
- Child Trauma
- Training on reflective supervision and specific model requirements are supported by the IBTI training facility.

- Prior to becoming a MIECHV funded community, each community had to demonstrate that they had a collaborative that consisted of early childhood providers as well as mental health, substance abuse, and domestic violence providers. To further develop and strengthen the collaborative, funding for a Community Systems Development (CSD) worker was provided for each community. The state’s expectations for this worker were advanced education as well as professional maturity and a body of work that could call agency decision makers to the table. A Community Impact Officer was hired as a contractual position to assist the Community Systems

and Capacity Building Manager with providing support to each collaborative. The CSD has specific performance standards and deliverables they must meet, which includes increased participation in the collaborative by not only non-profits but also businesses and the chamber of commerce. An increased number of MOUs are expected each quarter. Communities that hired a lesser-qualified person for the CSD have not performed well and ultimately had staff turnover. As part of a corrective action plan, the state now requires a state-level review of the last three applications for CSD positions and approval for hiring. To further support service referrals, the GOECD developed an inter-agency agreement with DCFS for the service provider database. This database contains contact information for all service providers in Illinois. These providers can be queried by geographic location or service need. Because this database is web-based, the home visitor can access service providers while at home visits and expedite services that the participant requires.

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Status of current and projected home visiting program caseloads within each at-risk community

Community, Agency, and Funding Amount	Model and Service Capacity	Number of Clients Served to Date	Number of continuing eligible families in at-risk community projected to be served during year one (September 1, 2013 – September 30, 2014)	Number of continuing eligible families in at-risk community projected to be served during year two (September 1, 2014– September 30, 2015)	Number of new families projected to be enrolled, by model, in at-risk community during year one (September 1, 2013 – September 30, 2014)	Number of new families projected to be enrolled, by model, in at-risk community during year two (September 1, 2014– September 30, 2015)	Attrition Rate
Cicero							
Children's Center of Cicero-Berwyn \$180,771.00	PAT - 60	73	60	60	60	60	20%
Family Focus \$225,000.00	PAT- 77	95	63	38	14	39	12%
Family Services & Mental Health \$180,812.00	CI & CSD	N/A	N/A	N/A	N/A	N/A	N/A
Elgin							
Family Focus \$120,543.00	HFI- 23	25	19	23	5	4	15.88%
Kane Co. Health Dept. \$207,616.00	NFP – 18 CI & CSD	12	6	3	12	17	50%
School District U-46 \$181,298.00	PAT - 38	48	20	20	24	24	6.25%
VNA Fox Valley \$120,543.00	HFI - 25	23	12	12	14	10	61%
Macon County							
Decatur Public School \$130,518.00	PAT - 30	36	20	20	10	10	36%
Macon Resources \$183,146.00	PAT- 30	31	24	16	7	15	23%

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Macon Co Health Dept. \$329,853.00	HFI - 18 CI & CSD	22	28	32	16	10	90%
Rockford							
Easter Seals \$111,371.00	HFI - 28	43	28	32	5	5	26%
La Voz Latina \$67,101.00	HFI - 18	13	11	11	7	7	15%
City of Rockford Human Services \$173,378.00	EHS - 23	28	15	7	10	11	16%
Rockford Public School 205 \$74,616.00	PAT -30	43	17	11	6	5	7%
Winnebago Health Dept \$203,532.00	CI & CSD	N/A	N/A	N/A	N/A	N/A	N/A
Southside Cluster (Englewood, West Englewood, Greater Grand Crossing)							
Children's Home + Aid \$229,321.00	CI, CSD, Community Impact Officer	N/A	N/A	N/A	N/A	N/A	N/A
ChildServ \$126,408.00	PAT - 38	58	20	20	24	24	64.1%
Family Focus \$125,000.00	HFI - 15	30	18	23	6	6	15%
Henry Booth House \$125,000.00	HFI - 40	40	26	40	14	14	100%
Women's Tx Center \$112,815.00	PAT - 20	68	12	8	24	14	68%
Vermilion County							
Project Success	CSD	N/A	N/A	N/A	N/A	N/A	N/A

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\$80,000.00							
Aunt Martha's \$324,635.00	PAT – 60 & CI	86	22	15	18	12	15%
Danville Consolidated \$57,729.00	PAT - 12	23	13	14	1	1	75%
East Central Com Action \$218,635.00	EHS -20	27	12	10	18	20	100%

- Participant recruitment and retention efforts
 - Recruitment: Recruitment efforts have been continuously monitored by IDHS and GOECD; particularly those aimed at hard to reach populations. MIECHV sites come together in learning communities in part, to learn what has proven successful to increase recruitment. Sites have used traditional and non-traditional methods: community health fairs, county fairs, agreements with OB/GYNs for referrals and literature, collaboration with programs that have entry points in birthing hospitals, including non-MIECHV home visiting programs in coordinated intake, cross-training staff to conduct intake for home visiting as well as other programs, increasing collaborative members, providing screens at Public Housing and other public gathering places. CQI is also addressing this as a state system issue.
 - Retention: When families have multi-system issues, retention is often an issue. Transiency and crisis often interferes with engagement. Learning communities have provided opportunities for sites to discuss ways to improve retention. Some of the methods implemented: case management services, incentives, supplying hard goods based on client needs, transportation assistance, family celebrations, doula services, support groups with free child care and food, support for coordination of services, newborn gifts to celebrate births, and normalizing home visiting within the communities.

- In Illinois, the MIECHV community collaborations are using the Collective Impact model. It is required for the collaboratives to have at the table health, mental health, early childhood development, substance abuse, domestic violence prevention, child maltreatment prevention, child welfare, education, and other social and health service providers in the community. Illinois believes strongly in the parallel process. It is expected that the governor's office will bring together the Department of Human Services, the Department of Public Health, the State Board of Education, the Department of Healthcare and Family Services, and the Illinois Coalition against Domestic Violence to work in partnership to support home visiting in Illinois. While this has been a challenge, MIECHV has been the catalyst for progress. Agencies that historically did not communicate with each other regarding services are now working together on birth outcomes, school readiness, and Medicaid. This example at a state level trickles down to communities as an example of collaborative work.

- The Illinois Department of Human Services (DHS) has a history of requiring fidelity to home visiting models, which includes affiliation and credentialing. The IBTI supports and monitors programs for fidelity. Chicago Public Schools (CPS) maintains high standards for programs that ensure model fidelity and quality. Both DHS and CPS conduct monitoring site visits on their funded home visiting programs. The Illinois State Board of Education does not monitor their home visiting programs, and therefore it is hard to determine fidelity to the model. This creates complications between the funders that do monitor for fidelity and the funders that do not. As a first step to mitigating this issue, the GOECD, through MIECHV, is bringing the state's major funders of home visiting together for the first time to discuss common goals, outcomes, requirements, and monitoring. Additionally, DHS will be monitoring State Board of Education and DHS funded programs that are supported by MIECHV. The monitoring will consist of quarterly site visits to agencies (each site visit will take two to three days) and include randomized file reviews, interviews with participants as well as home visiting staff, observations of home visiting sessions, review of supervision logs, and assessment of program standards and corresponding measures. All MIECHV programs are required to be model credentialed or affiliated to ensure fidelity.

Section 5: Progress Towards Meeting Legislatively Mandated Reporting on Benchmark Areas

Illinois has made significant progress in the collection of the federally mandated six benchmark areas. The state is utilizing a mixed method approach to data collection and has chosen a centralized MIS for all data collection across all sites to ensure an appropriate ability to report on the benchmarks in a consistent and reliable fashion. However, this does not mean that Illinois MIECHV has not faced challenges. Outlined below are the status and challenges associated with each Benchmark.

Note that data collection for all benchmarks has been standardized across all sites. This is specifically identified in the data plan. We ensure that all data is up to date by the time of the annual report, with an expectation that data be collected either as needed or quarterly, whichever is sooner. The exception to this is that all data collected by the CPRD team is collected at baseline and each subsequent year of service. This ensures that, as part of Illinois' data analysis and CQI plan, while we can report as needed in the annual report, we also have the ability to analyze change over time within individual families.

It should also be noted that a single challenge impacted all constructs in regard to data

collection and reporting over the past year. As noted previously, Illinois struggled with our initial MIS and Case Management system and found it necessary to rebid the contract, which ultimately led to the implementation of a statewide MIS based on DataKeeper Visit Tracker. Illinois believes that a solid and well developed case management front end is a necessary development for a good MIS in home visiting to help ensure data is entered in a timely manner (Home Visitors have greater intrinsic motivation to utilize the system effectively). Confusion over the use of the previous system and a lack of appropriate development for specific needs precluded the collection of some key data and the ability to collect a significant amount of data with errors during the first year of data collection. Now that Visit Tracker is being fully implemented across the sites, we have asked all sites to re-enter this data to remove the data entry errors found, and are hopeful that this will lead to cleaner data that better reflects our work on the benchmarks. CPRD's data reporting team is currently reviewing the initial data for review by the state administration team by August 13th 2013. First glance review of the data has already identified a few small data cleaning issues to be resolved, which informs our data review procedures are effective with the new data system, and we are able to now address these concerns far sooner than in the past year.

Maternal & Newborn Health

Illinois is collecting seven constructs within the benchmark area of Maternal and New Born Health. All data collection for this benchmark is done through a short interview process between home visitor and parent, and stored in the state MIS, Visit Tracker from Data Keeper. Two of the constructs have entailed the use of standardized measures and initial training of all home visitors was necessary to ensure the appropriate collection of this data. There have been few problems in the collection of this data and thus, the data is complete for families served by the program.

Challenges: There have been challenges in the collection of this data in two areas. First, an initial problem with the MIS system provided to the state of Illinois caused some missing data and cleanliness issues that needed to be resolved. However, the adoptions of a new data system and increased efforts to ensure complete and clean data entry have reduced these problems. A second challenge has been the training of a new assessment tool for the collection of one of the constructs. While it has not created problems in the accurate collection of data, it may have created some issues to be addressed as part of our CQI, to ensure best possible service delivery. This challenge will in fact, give us an area to see improvement in one of the constructs, and help to improve services across the state.

Child Injuries, Child Abuse, Neglect, or Maltreatment and reduction of emergency department visits

Illinois is collecting seven constructs within the benchmark of Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits. Collection of this data was designed to follow two stages. In the first stage, families would be asked questions to address each of the seven constructs, and this information would be held in the state MIS. The second stage involves the replacement of the self-report data with administrative data collected by the state through the appropriate state agency, Illinois Department of Public Health, Illinois Department of Human Services, and Illinois Department of Child and Family Services.

The challenges faced have primarily been in securing the appropriate administrative data. The state of Illinois has a known backlog for data entry as well as problems associated with the

length of time for certain data to be considered complete. The data must go through a cleaning and finalizing process that can take years. We have made great progress in securing access to the preliminary data, which, while not considered final, will give Illinois' team the ability to report on the necessary constructs. It is considered an unusual practice by the aforementioned organizations to allow reporting on preliminary data, and special agreements needed to be reached to assure the appropriate use of this data.

Improvement in School Readiness and Achievement

Illinois is collecting nine separate constructs in the area of Improvement in School Readiness and Achievement. This set of constructs represents an area of grave importance to the areas of impact had by home visiting. In order to ensure the highest quality and most reliable collection of this information, a mixed methods approach has been taken to the collection. While all data used is quantitative, the data collection method varies with each construct. Certain constructs utilized standardized assessment measures that, when utilized for impact reporting, typically have little value to practitioners or home visitors in their day-to-day practice, and reliable use of these assessments and measures can be very complicated. For those constructs utilizing a new standardized assessment in which its use for impact analysis differed substantively from that of its use in practice, and which high reliability required highly trained and experienced data collection experts, an external agency, CPRD, was contracted to collect this data. This ensures the state has a maximum ability of recognizing change in the home visiting services impact over time. For those measures that require standardized assessments already a common part of home visiting services (e.g. the ASQ's), home visitors were offered additional training, but collected this information on their own. All of this data is stored together centrally in the MIS.

Challenges: CPRD collected data requires a separate data collection home visit, and anticipated that this extra stress on the family could be difficult to overcome. It asks of families their willingness to allow a new person into the home for the collection of this information over a 60-75 minute period. The questions can be seen as invasive at times, and a great deal of trust is needed for the necessary rapport needed to ask these questions. To overcome this challenge, CPRD is utilizing the home visitor's relationship with the family in order to complete the visits. Home Visitors help to schedule the visits, act as a liaison between the family and data collector, and attend all interactions to ensure the family feels safe. To date the home data collection process has gone very well and this method of interaction has largely resolved the problems and concerns. CPRD has managed to collect data from more than 90% of all families served by the program since field data collection began. However, this approach did require full IRB review and approval by the University and as such, CPRD was unable to begin data collection at the same time that services started. This delay allowed for some families to leave services before the data collection process started and as such, their data was not collected. In addition, some families in Cohort 1 initially refused data collection, which we believe was due to a miscommunication to the goal of home data collection, and may have inadvertently concerned participating families. A correction in the language used to explain the procedures, and additional training with the home visitors seems to have largely resolved this. Of note, CQI is incorporated into this data collection process and we are actively reviewing refusals to data collection and feel we can further reduce this in the future.

Domestic Violence

Illinois has chosen Domestic Violence as one of its target benchmarks, and we are

collecting three constructs within this benchmark domain. The data collection process with domestic violence involved a great deal of initial home visitor training around the use of specialized screening tools for domestic violence. The trainings have largely helped home visitors to feel efficacious in the appropriate screening and thus collection of domestic violence data.

Challenges: There is trepidation among some home visitors around the appropriate screening of families facing severe domestic violence. There has been concern regarding the home visitor and family safety if domestic violence screening is administered. This concern is addressed in the training, and CQI will continue to monitor this issue. Illinois feels this will lessen in time as home visitors, some who have never been responsible for domestic violence, screening and safety planning, become more comfortable in their approach to discussion DV issues with families.

Family Economic Self-Sufficiency

For the benchmark on Family Economic Self-Sufficiency, Illinois is collecting four constructs. These constructs rely on family self-report to the home visitor, and is stored as part of the state central MIS. This process has involved a few

Challenges: Home visitors had not previously collected this information in the way MIECHV required and they were concerned that collection of his data may interfere with family engagement and trust. Training for home visitors on the best way to ask and record this information has helped to ensure that the data is collected completely. There are no additional major challenges still being faced, and this information is collected as part of the home visiting routine, and updated quarterly by home visitors, or as indicated by the family.

Coordination and Referrals for Other Community Resources and Supports

This Benchmark contains five constructs, and of these constructs, three constructs deal directly with family referrals and referral completion, and two are based on community development. As a result, three constructs are collected by the home visitors at the family level and aggregated for the annual report to HRSA. Two of the constructs are collected as part of the community development work across our six state communities in the Illinois MIECHV project, and as such, are reported and aggregated from the community level. The first year's report relied on community development data collection to be separate from the State MIS, but moving forward, it was decided to report and store this information through the same central MIS, to ensure consistency and make organization of the community development easier.

Challenges: From a data collection and report standpoint, no challenges of note were faced. However, this set of constructs is the focus of the first CQI project to be undertaken by the state and all home visiting agencies. Meaning, referral services are the current focus of sites in their first CQI project, and a CQI lens is now being introduced to the community development and expansion.

Section 6: State Home Visiting Quality Improvement

Continuous Quality Improvement (CQI) implementation in the Illinois MIECHV project is now well established across all sites and at the state level. In March, 2013 a finalized CQI plan was submitted to HRSA for review, and a series of meetings were completed across the state to inform sites of the state's CQI plan, and the requirements of the individual sites.

Development of the State CQI

The state of Illinois contracted with the Center for Prevention Research and Development in order to construct a statewide CQI approach that would offer technical assistance to sites and to coordinate a statewide CQI effort to help monitor and improve home visiting through an appropriate QI lens. CPRD developed a unique statewide plan known as the Illinois Home Visiting Improvement Model, based largely on Models for Improvement and Six Sigma CQI approaches. The primary reason for modifying and renaming the CQI approach within the CQI is to ensure the state and sites enough flexibility in the implementation of a large scale CQI program that would not be constrained by practices developed in the CQI program to serve differing purposes. For instance, if Model for Improvement was already in use at a particular site, CPRD has experienced that differences in the adaptation of this approach to a state system may hinder integration with existing MI systems, as the two systems may be perceived as incompatible. While the core tenants of the state's approach remain the same, there is a psychological effect of breaking down barriers to statewide integration by taking a fresh approach with a new name. We believe this will maximize buy in. In addition, we have included a statewide Culture of Quality Marketing campaign that is utilizing our states new Quality Improvement mascot, the Quality Koala.

Implementation of CQI at the State and Site Levels

Illinois, as indicated, has completed initial meetings with all sites to help unroll the state CQI program. Sites have begun discussion on the way they will implement a CQI program, the kinds of data access they have or need, and the way they intend to integrate with the state level CQI program. At the end of July 2013, the first quarterly online meeting has been planned to empower sites with the common tools of CQI and help them begin the implementation of the CQI style problem solving process. This will be a coordinated effort across all sites to help the CPRD technical assistance team effectively work with the sites. Direct technical assistance with sites will begin following the first quarterly meeting.

CQI Readiness

Utilizing a series of questions drawn from academic journal peer reviewed quality improvement implementation surveys, CPRD conducted a survey with all sites to ascertain the readiness of the site around CQI implementation. The surveys were designed to address the degree of implementation at a site and how deeply the culture of quality has penetrated the work process of an organization.

Following the completion of this survey across the sites, CPRD has begun an analysis process of the survey data to assess the degree of readiness in each of the six communities, as well as the state as a whole. This data is being analyzed using a mixed methods approach of qualitative review of open-ended responses and quantitative review of responses. To date CPRD has already discovered interesting patterns in the nature of responses by both community area and staff position held by the responded. As such, we feel this information can be utilized to triage the technical assistance needs of the sites. The results of this survey will be revealed to sites at the CQI quarterly webinar meeting.

CQI Projects undertaken

CPRD identified that Illinois home visiting's first "low hanging fruit project" for the initial CQI project would be focused on the external referral process integral to a home visitor's

case management role. Referrals, referral acceptance, and referral completion were identified as the three major areas for problems to arise in the process of referral case management. It was further broken down into two potential causes of a referral not being made or completed. First, was the area of the home visitor's work, and second, was a lack of community resources for appropriate referrals to be made. Both the Community Development Worker and home visitors are working together on two separate aspects of the referral process for their referral solution. They are currently at the early root cause analysis phase, and thus are focusing on impediments to the process. This will be reviewed at the next quarterly meeting, and a set of next steps will be developed for implementing a testable improvement plan.

Since data is the core of the procedures used in QI, CPRD helps sites identify sources of data. Two primary sources of data are sites' own case notes as recorded in Visit Tracker, and the *4P's Plus* tool which involves screening parents for domestic violence, substance abuse, tobacco use, and maternal depression - the primary areas for which referrals are made. These two sources of data allow the home visitors to assess their work regarding identified referral needs, actual referrals made, referrals accepted, and referral sources available. To interpret the data and develop a plan of action around the findings, CPRD, in conjunction with the Governor's Office and DHS, has been reviewing the data available from the *4P's Plus* and in discussion with the developer, Ira Chasnoff. In order to help sites see the typical CQI process (identified problem, data review, root cause analysis, identification of measures for the process and problem outcome, and finally development, implementation, and review of an improvement plan) it was decided CPRD would work with its technical assistance team and the sites to review the findings before implementing a plan. Because the same problem was identified for review across sites, the same data is being used, and the same root cause analysis, the actual plan for improvement will be fairly unified across sites and implemented across the state with more intense state support and development than may be typical for such problems in the future. Sites will be supported to see the way a problem can be identified through casual means (Supervisors may feel their home visitors are not making as many external referrals as is necessary for the problems observed), or they can review concrete data sources to check their hypothesis, proceed with a root cause analysis to identify the process by which road blocks to service delivery take place, develop an improvement plan around the identified root causes and processes involved, implement this plan. Most importantly, the sites will understand the need to implement a review process on the progress of this plan, and its impact on the desired outcome areas

Section 7: Administration of Home Visiting Program

- Updated organization chart (attachment 4)
- Estimated unobligated balance of HRSA FY 11 formula funds: \$0
- Estimated unobligated balance of HRSA FY12 formula funds: \$ get from Andrea
- New policies created by the state to support home visiting programs:
 - The Home Visiting Task Force Executive Committee approved the MIECHV CQI plan for use to support improvement in home visiting programs throughout the state.

Attachments

Attachment 1: Project Timeline and Logic Model

Attachment 2: Staffing Plan and job Descriptions for New Key Personnel

Attachment 3: Maintenance of Effort Chart

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Attachment 4: Updated Organization Chart

Attachment 5: Descriptions of NEW Proposed/Existing Contract (subcontracts)

Attachment 6: Model Developer Letters, for models not previously implemented (if applicable) – Not Applicable

Attachments 7- Coordinated Intake Flow Chart